

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2017
NAME OF PROVIDER OR SUPPLIER NORTHCREST SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HEATH STREET WATERLOO, IA 50703		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS ✓ 5/5/17 Correction date <u>3/23/17</u> <i>immed correction</i> <u>4/12/17</u> <i>overall correction</i> The following deficiency relates to investigation of incident #67397 & #67294. (See code of federal regulations (42CFR) Part 483, Subpart B-C) Complaint #67394 was not substantiated. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 000			
F 323 SS=G		F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 by: Based on clinical record review, facility protocol and interviews, the facility failed to ensure one (1) of five (5) residents received adequate supervision to protect against hazards in the environment. Record review, facility protocol review and staff interviews revealed Resident #2 required the use of a personal safety alarm, pressure alarm at all times, and staff to encourage gripper socks or shoes on at all times due to fall risk. On 3/15/17, staff left Resident #1 in bed with pressure alarm in place, but failed to confirm alarm box turned on and functioning and placed socks on resident were not gripper socks. Resident #2 stood, fell and sustained a subdural hematoma (collection of blood outside the brain) and required admittance to the hospital. The facility reported a census of 92 residents. Findings include: The Minimum Data Set (MDS) assessment with a reference date of 2/14/17 for Resident #2 documented a score of 7 of 15 on Brief Interview for Mental Status (BIMS) test which indicated severe cognitive impairments. According to the MDS, the resident required the extensive assistance of one staff for transfers, dressing, and walking in room/walking in corridor. The MDS further identified the resident required limited assistance of one staff for bed mobility personal hygiene and toilet use. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when walking, turning around, and surface to surface transfers. The resident had diagnoses that included non-Alzheimer's dementia, Diabetes Mellitus, anxiety and depression. The resident had had experienced	F 323			

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F 323	Continued From page 2 two or more falls with no injury since admission or reentry or prior assessment. Review of the Risk Assessment for Falls dated as completed on 2/13/17 identified the following risks for falls: intermittent confusion, three or more falls in past three months, chair bound, decreased muscular coordination, required use of assistive devices for gait/balance, medication use, and predisposing diseases. The Risk Assessment for Falls documented a score of 18, a score of 10 or more represented a high risk for falls. The Resident Care Plan with a problem onset date of 8/29/2014 identified a potential for injury related to fall history. The Care Plan identified a goal of no injury sustained from fall with a target date of 5/17/17. The approaches directed staff to use a pressure alarm in bed and wheelchair dated 11/18/16, encourage gripper socks or shoes all times-as able dated 11/25/16, monitor resident frequently with rounds dated 3/8/17. The Care Plan identified the following recent falls: 3/8/17-self transfer, found on floor in room 3/7/17-found on floor at foot of bed 2/27/17-fall found in doorway 1/30/17-fall bathroom 1/25/17-fall out of recliner in room 1/15/17-fall activity room 1/4/17-fall self- transfer A timeline of falls for Resident #2 identified the following: a). On 10/18/16 a personal alarm was added after the resident had fallen in his/her room while attempting to use the bathroom unassisted. b). On 11/24/16, gripper/shoes after the resident had fallen in the bathroom. c). On 1/30/17, a pressure alarm added after	F 323			

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F 323	Continued From page 3 resident had fallen on bathroom floor. Resident #2 had used the resident unassisted. A fall incident report dated 3/15/17 at 6:35 a.m. documented Staff A, licensed practical nurse, (LPN) observed Resident #2 laying on floor on back at the foot of bed. Noted socks were not gripper socks, alarm not sounding, and the residents head laid in a large amount of blood. The nurse assessed the resident and noted an approximately 2 cm laceration (tearing of skin) over a golf ball size hematoma (lump from collection of blood) on the left side of the residents head. Staff transferred the resident to the hospital Emergency Room for evaluation and treatment. The hospital provider note dated 3/17/17 at 1:10 p.m. documented Resident #2 arrived at hospital with an intracranial bleed after being found down at the nursing home. When the emergency medical staff arrived (at the nursing home), the resident already had blood coagulated in his/her laceration identifying he/she may have been down for some time. A laceration was noted to the back of the head, EMS transported to a local hospital and a CT scan of the resident's brain was positive for a subdural hematoma. The resident discharged back to the nursing home in stable condition on 3/17/17. During an interview on 4/12/17 at 11:11 a.m. Staff A, LPN, confirmed on 3/15/17 she heard Resident #2's roommate yell for help, she entered the room and observed Resident #2 on the floor at the foot of the bed, laid on back, with blood noted all around the resident's head. Staff A noticed the bed pressure alarm was not sounding and noted	F 323			

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F 323	Continued From page 4 the socks the resident was wearing were not non-skid socks. Staff A reported she called for help, and requested Staff B, CNA (Certified Nurse Aide) check the alarm. Staff A reported she was informed by Staff B the alarm was not on. Staff A stated it is an expectation that all alarms are checked at the beginning of the shift during walking rounds, clarified that the day shift began at 6 a.m. Staff A revealed on 3/15/17 staff failed to complete walking rounds because of lack of staffing. Staff A further clarified that the resident was to have a pressure alarm on at all times when in bed and was to wear non-skid socks and but was found to be wearing socks that were not non-skid. In an interview on 4/12/17 at 12:20 p.m. Staff B, CNA confirmed on 3/15/17, Staff A, LPN requested she check the resident's bed pressure alarm after Resident #2 was discovered on the floor. Staff B confirmed the alarm was not sounding when she entered the room. Stated the alarm monitor was attached to the bed side rail and the monitor was connected to the pad pressure alarm. Stated she assumed the alarm was not on because it was not sounding. Staff B demonstrated on the actual alarm removed from the resident's room that the on/off button is not easily visible, and stated she did not have her glasses on so could not see. Clarified that she would normally test a pad pressure alarm by putting pressure on the pad, releasing and listening for audible alarm but confirmed she failed to test the resident's alarm after the fall. In a phone interview on 4/12/17 at 4:00 p.m. Staff C, CNA, confirmed she had assisted the resident to toilet at 5:30 a.m. on 3/15/17 and returned the resident to bed. Confirmed the alarm was in	F 323			

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F 323	Continued From page 5 place attached to the side rail. Confirmed failed to complete walking rounds to check alarms during shift. Review of an Internal Investigation Witness Statement dated 3/15/17 documented staff D, CNA responded to questions from the Director of Nursing (DON). Staff D, CNA reported to work at 6:00 a.m. on 3/15/17. Staff D responded that she had not checked alarms when came in to work and failed to complete walking rounds to check alarms because she was answering call lights. In an interview on 4/12/17 at 2:45 p.m. the Administrator stated has always been an expectation that staff check alarms are in place and functioning at the beginning of every shift in addition need to check alarm every time alarm put in use. Confirmed staff failed to check alarms on 3/15/17. Clarified following the residents fall have implemented measures to monitor and hold staff accountable.	F 323			

Northcrest Specialty Care

Waterloo, Iowa

May 3, 2017

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Alarm that had on-off switch was removed from resident #2's bed on 03/15/2017.

All alarms with the on-off switch were replaced by 03/23/2017.

After 04/12/2017 Facility Staff performing routine audits to ensure Fall Interventions including but not limited to alarms on and functioning are in place.

Northcrest Specialty Care

Waterloo, Iowa

Plan of Correction sent 5/1/17

F323

Preparation or execution of this plan of correction does not constitute and should not be interpreted as an admission or an agreement by the facility of truth of the facts in the statement of deficiencies. The plan of correction for this deficiency was executed solely because of provisions because state and federal requires it.

In respect to Resident #2 resident is no longer monitored by alarms. All similar situated residents are being monitored with alarm boxes that do not have an off on switch. Further interventions put in place for Resident #2, soft helmet, mattress on floor when in bed, encourage to attend activities and to remain in common areas, offer to toilet, offer to provide bible and baby doll when in wheelchair and place bible under pillow at night.

Staff was re-educated on applying gripper socks and checking that alarms are on and functioning. To ensure compliance the QA team will monitor routinely for alarm functioning, any concerns will be discussed at QA meetings. DON or designee will perform random audits for ongoing compliance with gripper sock and alarms.